ARC 9728B

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 249A.4 and 2011 Iowa Acts, House File 649, section 35, subsections 6(d) and 7, the Department of Human Services hereby amends Chapter 92, "IowaCare," Iowa Administrative Code.

Federally qualified health centers designated as IowaCare medical home providers have expressed concern about their limited ability to provide medically necessary care to IowaCare members. Federally qualified health centers without on-site laboratory or radiology services have to pay outside sources in order to provide those services to IowaCare members. Also, IowaCare does not cover home health services, durable medical equipment or rehabilitation and therapy services that may be needed by a member recovering from an inpatient stay. Failure to provide these services may result in readmission to the hospital.

In response to these concerns, the Eighty-Fourth General Assembly has created two new capped funding pools, a care coordination pool and a laboratory test and radiology pool, to help medical homes defray the cost for medically necessary care not otherwise covered under IowaCare. These amendments:

- Establish covered services to be reimbursed through the new funding pools;
- Establish protocols for referral of IowaCare members to another provider;
- Make a technical correction to clarify that members are assigned to, rather than enrolled in, medical homes; and
- Require IowaCare providers to develop a process to improve communication and resolve care disputes when referring members for specialty and hospital care.

The Council on Human Services adopted these amendments on August 10, 2011.

In compliance with Iowa Code section 17A.4(3), the Department finds that notice and public participation are contrary to the public interest because the General Assembly appropriated these funds to meet specified needs of IowaCare patients. The public interest would not be served if this funding was withheld to provide time for notice and public participation.

The Department finds that these amendments confer a benefit on IowaCare members who need care not offered by their medical home by providing funding streams to pay for that care. Therefore, these amendments are filed pursuant to Iowa Code section 17A.5(2)"b"(2), and the normal effective date of these amendments is waived.

These amendments are also published herein under Notice of Intended Action as **ARC 9729B** to allow for public comment.

These amendments do not provide for waivers in specified situations. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code chapter 249J and 2011 Iowa Acts, House File 649, section 35, subsections 6 and 7.

These amendments became effective on September 1, 2011.

The following amendments are adopted.

ITEM 1. Amend paragraph **92.8(6)"c"** as follows:

c. If an IowaCare member resides in a designated county near a designated medical home provider, the department shall ~~enroll~~ assign the member ~~with~~ to that provider. ~~A~~ If an IowaCare member who is ~~enrolled with~~ assigned to a medical home ~~provider~~ chooses to go to another provider without a referral from the medical home:

(1) ~~Shall utilize the medical home provider for covered services available from that provider~~ The service is not covered by the IowaCare program, and

(2) ~~Must receive a referral from the medical home provider to another IowaCare provider for any services not available from the medical home~~ The provider may bill the member according to the provider's established criteria for billing other patients.

ITEM 2. Amend subrule 92.8(7) as follows:

92.8(7) ~~*Emergency services*~~ *Services from nonparticipating providers.*

a. A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

(1) to (4) No change.

~~(5) The treating nonparticipating provider has consulted with the IowaCare provider network hospital and the providers jointly agree that the conditions for payment are met.~~

~~(6)~~ (5) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services ~~and documentation of the consultation with the IowaCare network provider~~.

b. No change.

c. Care coordination pool. A care coordination pool is established to provide payment for medically necessary services provided to IowaCare members for continuation of care provided by a participating IowaCare hospital. Reimbursement is available from designated care coordination pool funding subject to the following conditions:

(1) Payment may be made for continuing care that is related to an IowaCare member's hospital services as determined in a referral from the participating IowaCare hospital.

(2) Payment for continuing care is available to providers that are enrolled in the Iowa medical assistance program, regardless of whether the provider is a participating provider for IowaCare and regardless of the member's county of residence or medical home assignment.

(3) A provider of continuing care that does not participate in the IowaCare program must include information regarding the referral on the claim form.

(4) Payment shall be made only for services that are not otherwise covered under the IowaCare program. Payment shall not be made for services that would normally be provided by the IowaCare provider to other non-IowaCare patients.

(5) The type, scope, and duration of payable services shall be limited as determined by the department. Payable services are limited to:

1. Durable medical equipment.
2. Home health services.
3. Rehabilitation and therapy services, including intravenous antibiotics and parenteral therapy delivered at home.

(6) Types of items or services that are not covered include, but are not limited to:

1. Adult diapers.
2. Air compressors.
3. Bedside commodes.
4. Blood pressure kits or machines.
5. Cardiac event monitors.
6. Continuous passive motion machines.
7. Continuous positive air pressure (CPAP) machines.
8. Dental care (nonsurgical).
9. Eyeglasses, contact lenses, and eye prostheses.
10. Gel shoe inserts.
11. Hearing aids.
12. Heated oxygen.
13. Laboratory tests and radiology procedures.
14. Oral supplemental formula.
15. Outpatient pharmaceuticals not specifically identified in 92.8(7)*"c"*(5) above.
16. Ted hose, Sigvaris stockings, or Jobst stockings.
17. Tennis shoes.
18. Transcutaneous electrical nerve stimulation (TENS) units.
19. Transportation.

20. Work boots.

(7) All other medical assistance program policies affecting the payable services shall apply, including those regarding prior authorization and level of care determination.

(8) Payment is limited to the amount of available funds designated for the care coordination pool.

d. Laboratory test and radiology pool. A funding pool is established to provide payment for medically necessary laboratory tests and radiology services provided to enrolled IowaCare members when authorized by a federally qualified health center that has been designated by the department as part of the IowaCare regional provider network. Payment from the pool shall be subject to the following conditions and limitations:

(1) Payment may be made only for laboratory tests or radiology services which the participating federally qualified health center does not otherwise have the means to provide on site.

(2) Each participating federally qualified health center shall designate no more than four laboratory testing facilities and no more than four radiology facilities to which the center will refer IowaCare patients for these services. The designated providers must participate in the Iowa medical assistance program. Payment shall be made only to the designated providers.

(3) The designated provider must obtain a referral from the participating federally qualified health center for the services and must include information regarding the referral on the claim form.

(4) All other medical assistance policies for coverage of laboratory and radiology services shall apply, including requirements for prior authorization.

(5) Payment is limited to the amount of available funds designated for the laboratory test and radiology pool. If the amount appropriated for the pool is exhausted, laboratory tests and radiology services ordered by a participating federally qualified health center shall be provided or coordinated by the center.

ITEM 3. Adopt the following **new** subrule 92.8(8):

92.8(8) *Referral protocols.* When an IowaCare primary care provider refers the member to an IowaCare specialty provider, the following conditions shall apply:

a. By January 1, 2012, IowaCare providers shall ensure that referral and patient access processes for IowaCare members are no more restrictive than the processes required for any other payor.

b. After an IowaCare provider makes a referral, the IowaCare provider receiving the referral shall report the following information to the referring provider in a manner chosen by the provider receiving the referral:

(1) The date an appointment has been scheduled. The appointment date shall be reported to the referring provider within 15 calendar days of receiving the referral. If the referral is denied, the receiving provider shall offer a consultation by telephone, fax, E-mail, or Internet regarding the reason for the denial.

(2) If authorized by the IowaCare member, the outcome of the appointment, including whether the appointment was kept, the treatment plan, and any follow-up instructions. This report shall be made no later than 15 calendar days following the appointment date.

c. IowaCare providers shall work together to address any communication or coordination issues that arise. By October 1, 2011, IowaCare providers shall jointly develop and implement:

(1) A process to resolve disputes regarding care needs, payment and referrals that includes regular meetings between providers.

(2) A process to identify and address quality improvements with a goal to improve coordination of care between primary, specialty and hospital care. This process shall be monitored by the department but be managed and staffed by the providers.

[Filed Emergency 8/16/11, effective 9/1/11]
[Published 9/7/11]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 9/7/11.